

NOTICE OF INDEPENDENT REVIEW DECISION

Date: April 7, 2003

Requester/ Respondent Address: Debra Hausenfleck, TWCC
4000 S. IH-35, MS-48
Austin, TX 78704-7491

RE: MDR Tracking #: M2-03-0712-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon physician reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon physician reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

The claimant reportedly suffers from chronic low back pain following a compensable work injury of ___. A clinic note of 2/3/03 discusses the diagnosis of discogenic pain at L5/S1 due to a disruption in the annulus. He specifically states that because the disc herniation is small, it is not causing any nerve root compression, but that the lack of neurologic findings does not mean that the claimant does not have pain from the torn anulus. On the other hand, another physician's note indicates in a clinic note dated 12/11/02 that the claimant suffers from lower extremity tingling, numbness and weakness; that a transforaminal epidural steroid injection at the levels of L5 and S1 nerve roots are indicated, that an epidurogram would be anticipated to assess the presence of scar tissue or adhesions of the nerve roots, and should scar tissue be found, a lysis of adhesions with the use of a spinal catheter would be performed. The physician indicates in his clinic note of 12/11/02 that the lumbar radiculitis may be due to scar tissue or adhesions and that this requires a transforaminal approach.

Requested Service(s)

Three (3) transforaminal epidural steroid injections at L5/S1, epidurogram, lysis of adhesions and use of spinal catheter.

Decision

I agree with the insurance carrier that the requested services are not medically necessary.

Rationale/Basis for Decision

There is inadequate documentation to support the requested services. There is some discrepancy between the clinical impressions of the two physicians. On the one hand, the first doctor feels that the pain is due to a torn anulus while the second doctor feels the pain may be due to scar tissue or adhesions of the nerve roots of L5 and S1. Objective documentation indicates that there is no significant nerve root involvement. An MRI report of 11/18/99 indicates degenerative disc at L5/S1 and a focal subligamentous disc herniation that does not indent the thecal sac or the exiting nerve roots. An EMG/NCV study performed on 10/17/02 was entirely normal with no electrophysiological evidence of lumbar radiculopathy, lumbosacral plexopathy, or distal mononeuropathy. The claimant's neurologic exam has been normal on numerous occasions as documented by the treating physicians. It is not at all clear at this time how a transforaminal epidural steroid injection will effectively treat a discogenic clinical condition. There is no objective documentation of nerve root pathology to indicate the medical necessity of a transforaminal procedure with epidurogram and lysis of adhesions. As such, the documentation does not support the medical necessity of the requested intervention.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (pre-authorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 7th day of April 2003.
